Marshfield Clinic
Health System

Medical Care Complaint Request

Marshfield Clinic Health System (MCHS) values the opportunity to learn from patients and address all concerns. This form is used to file a complaint with MCHS for care received in hospital or clinical settings.

Name of patient ______________________________________ Date of birth (m/d/y) ________ /________ /________

Facility and department name ______________________________ Date of service (m/d/y) ________ /________ /________

Medical history number (if known) ______________________________ Phone ______________________________

If you are not the patient, your name and relationship to patient ______________________________________

Reason(s) for complaint: ____

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Resolution or desired outcome sought: ____

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Signature ____ Date (m/d/y) _____ /_____ /_____

Note: *Complaints and grievances are not required to be in written form. They can also be submitted verbally by calling the number below.*

Send completed form to:
Administration
Marshfield Clinic Health System
1000 N. Oak Avenue
Marshfield, WI 54449

Or call: 715-387-5300

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